printing this personal attack disguised as a special communication. The real scandal is that Dr. Strandness wants the rest of the medical community to treat patients with cerebrovascular disease with empiricism, instead of scientifically and rationally establishing the basis for effective therapies.

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24/41/65753

Reply

To the Editors:

I was a bit surprised by the nature of Dr. Chaturvedi's response to my special communication. Apparently he did not read it carefully or chose to ignore the major points that I raised. He should understand that my decision to write this came about after several months of attempting to find out what really happened with the Data Monitoring and Safety Committee (DSMC). I need not repeat what was said except to emphasize that he failed to address my concerns that I believe are important. In brief, I addressed those issues that were legitimate. For example, why wasn't the protocol enforced in many areas? Why wasn't the DSMC informed of changes in the protocol? Why didn't the DSMC committee meet for 30 months? Why did Dr. Walker, at the insistence of Dr. Barnett, remove Dr. Imparato and myself from the DSMC without even telling us this had happened? Why didn't the National Institute of Neurological Diseases and Stroke insist that their own guidelines for clinical trials be followed? Why weren't the many questions raised by me and other members of the DSMC ever answered? Please—let us deal with the issues that were legitimately raised.

Some of his other concerns baffle me because they were not raised in my communication. He apparently considers me an impediment to scientific scrutiny and accuses me of urging the medical community to treat cerebrovascular disease with ignorance and not good science. I have made several contributions to this field, and every finding that I published has been found to be true. If Dr. Chaturvedi has evidence that my work has lead to darkness and not to light, he should produce that evidence. In fact, my recommendations concerning the role of carotid endarterectomy have been conservative by many standards and remain so.

Finally, I hope that Dr. Chatuverdi will try to understand my role and the pathway that I chose. When I believed that there were serious gaps in what I knew, I chose to use the Freedom of Information Act (FIA). I was astounded by what I found, and there is more that is not in my communication. I did not undertake this task lightly but believed it was my duty to inform the medical world of the facts as I found them and were borne out by the information I received through the FIA. If my allegations are incorrect, then please correct them. If I am wrong and it can be shown to be the case, I will be the first to admit it. However, I reject the unsupported allegations about my scientific credibility. I will let my publication record stand on its own for all to read. I just wish Dr. Chatuverdi had done a careful review of what I have published and not accused me of the *scandal* that he believes I am a party to.

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24/41/65754

Simplified suturing of the calcified aorta

To the Editors:

We are in agreement with the comments of Hutson et al. (J VASC SURG 1994;19:1098-9) about the difficulties of suturing the calcified aorta. This problem also arises in other vessels and should not be underestimated. However, we cannot agree that "it is difficult to find described" procedures for this problem. The technique of crushing the arterial wall to fragment the calcification is well described by Ascer et al.[1] and is complete with a 5-year follow-up for infrapopliteal bypass. Other authors have suggested endarterectomy before suturing because the calcification is confined to the intima and media.[2]

In passing we note his technique is very similar to that of Carpenter and Berkowitz,[3] who used a 23-gauge hypodermic needle as drill bits as recently as 1992 in this journal. Andrus[4] described an elegant method of bracing the arterial wall with a cotton dissecting swab (possibly a dental pledget) to prevent shearing and plaque fracture. Triangular shaped needles held by needle holder and used as an auger was described by Melliere et al.,[5] who also suggested the use of an electric dental drill for the purpose. This method allowed a successful bypass to be constructed in 14 otherwise "impossible" cases.

Prompted by these studies we were surprised not to find a description of the following technique, which is simple but no less effective and does not require any additional instrumentation than that present on all basic surgical trays. The standard Backhouse towel clip has two sharp points that just fail to meet, when the instrument is closed. The offending arterial wall is pierced with the towel clip in two or three sites within 2 to 3 mm of the arteriotomy and of each other. This breaks the calcification but does not disrupt the fibrous tissue in the vessel wall because the tips do not meet. The hole is mainly in the calcification and so allows safe passage of the suture

without destroying the strength of the arterial wall, and the anastomosis. In an experience of many years, no episode of hemorrhage has resulted. If the arterial wall is friable and calcified, patching with Teflon felts on the outer surface of the arterial wall may be all that is needed to secure the stitch.

In the United Kingdom cost containment and resource management have focused attention on simple inexpensive yet effective techniques, which also avoid turf wars with owners of the orthopedic and dental drills. We suspect that Dr. Hutson's method may lead to undue hemorrhage for patient and surgeon alike!

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24/41/64195

Reply

To the Editors:

I want first to compliment Drs. Carpenter and Melliere on an excellent idea and second to apologize for not citing their publications. I assure you that this was not intentional and indeed find that I must add Dr. Friedman[1] to the list. The use of a straight needle as a bit (as described by Carpenter) is certainly an appropriate choice because they are readily available and function satisfactorily. We found, however, that these needles tend to "wobble" even when shortened considerably, and thus we changed to the broad-based drill bit. The use of a dental drill, as described by Melliere, seems to be the best choice of instruments because of its size and right angle configuration. We have simply not been able to have this readily available and thus have no experience with its use. Otherwise, it would be my first choice. I was introduced to "crushing" as a solution to this problem, 25 years ago, and have used this technique on a number of occasions. I find it to be crude, at best. In addition, the vessel must be completely mobilized and, as pointed out by Friedman, this is often undesirable. The use of a towel clip seems analogous to chewing a steak with only one upper and one lower tooth—which don't meet.

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REFERENCE

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The role of an ipsilateral carotid artery lesion on carotid subclavian bypass patency

To the Editors:

We read with interest the study by Vitti et al. (J VASC SURG 1994;20:411-8). The authors report their large experience (124 patients) on carotid-subclavian bypass (CSB) with excellent results (5- and 10-year patency rates were 98% and symptom-free survival rates were 90% and 87%, respectively). They did not notice any significant adverse effect of a concomitant carotid artery endarterectomy on short- and long-term bypass patency. Similar results were in fact observed with or without an associated carotid endarterectomy. Moreover they concluded by claiming that CSB in a safe, highly efficacious, and durable procedure in the treatment of symptomatic occlusive disease of the proximal innominate and subclavian arteries.

Conversely, in our experience[1] the presence of a concomitant ipsilateral carotid artery lesion, regardless of whether it is surgically treated, at the time of the extraanatomic procedure represented an important risk factor for the CSB patency. The 5- and 10-year patency rates were in fact 100% for CSB grafts performed on patients without a concomitant carotid artery stenosis and 66% and 40.8%, respectively, for CSB performed on patients with an ipsilateral carotid artery lesion ($p < 0.05$).

The detrimental effect of an ipsilateral carotid artery lesion was also observed by Edwards et al.[2] in four patients who underwent carotid-subclavian transposition (CST). One patient who underwent a CST and a concomitant carotid endarterectomy had a fatal stroke after 18 days. In the remaining three patients the progression of the proximal common carotid artery lesion caused a midterm thrombosis (one case) or symptom recurrence (two cases).

The rare presence of an ipsilateral carotid artery lesion in patients affected with a subclavian steal syndrome should dissuade the surgeon to perform a CSB and suggest the use of an axilloaxillary bypass graft. In our series the 5- and 10-year rate of axilloaxillary bypass in these patients were 100% (overall 87.9%).

We also disagree with the authors on the value and correct use of CSB in the treatment of proximal innominate artery lesion. In our opinion the presence of this lesion contraindicates the use of CSB or CST and recommends the use of an axilloaxillary bypass graft or an anatomic revascularization procedure.